TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Physicians Surgical Hospital

**Respondent Name**
Texas Mutual Insurance

**MFDR Tracking Number**
M4-17-3378-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
July 20, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The claim was placed with EnableComp by the client, Ardent Health Services, on 11/17/16. It was worked by the Revenue Specialist on 12/02/16. The work comp payer information was validated and the claim was ready for billing."

**Amount in Dispute:** $12,215.88

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor's bill is untimely. Texas Mutual received the bill 2/8/7. The creation date of the bill is 2/8/17, a date that exceeds 95 days from 10/14/2016 [sic], the date of service. Further, the only explanation provided by the requestor is "…we did work this account within timely filing limits…" but failed to submit the bill timely.

**Response Submitted by:** Texas Mutual Insurance

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| October 14, 2016 | 29806 –LT, 29999, 64415 -59, LT | $12,215.88 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out requirements for medical bill submission by health care providers.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired

**Issues**

1. Has the requestor waived their right to medical fee dispute?

**Findings**

1. The requestor states, "The claim was placed with EnableComp by the client, Ardent Health Services, on 11/17/16. It was worked by the Revenue Specialist on 12/02/16."

   Review of the submitted documentation found no billing to support a claim was submitted on this date. However, a document with a date of December 13, 2016 that is addressed to the employer, "Poole Chemical Co." asking for payment in the amount of $28,564.63.

   28 Texas Administrative Code §133.20 (j) states in pertinent part,

   > The health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following:
   >
   > > (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to:
   > >
   > > > (A) prompt payment, as provided by Labor Code §408.027;
   > > >
   > > > (B) interest for delayed payment as provided by Labor Code §413.019; and
   > > >
   > > > (C) medical dispute resolution as provided by Labor Code §413.031.

The Division finds the original request for payment was made to the injured employee's employer (Poole Chemical Co Inc.). Therefore, the requestor has waived their right to medical dispute resolution

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | | |
|---|---|---|
| | | August 9, 2017 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.